simulations were performed to propagate the uncertainty of parameters. **RESULTS:** The expected cost (and its credibility intervals of 95%) of the prevalent population with AH, DM and dyslipidemia using prices from public health system was in Chilean pesos (CLP$) CLP$12,463MM (CLP$11,394MM – CLP$13,622MM), CLP$36,425MM (CLP$25,603MM – CLP$49,624MM) and CLP$20,658MM (CLP$11,090MM – CLP$33,284MM) respectively. While, the estimated cost based on private health system was CLP$700,613MM (CLP$561,764MM – CLP$865,354MM), CLP$333,921MM (CLP$253,963MM – CLP$436,879MM) and CLP$680,919MM (CLP$327,916MM – CLP$1,645,906MM) respectively. **CONCLUSIONS:** The expected cost needed for the treatment of the three conditions studied represent 1.3% and 2.9% in the worst case scenario (33% considering private system prices) of the 2014 health budget, and the effort to improve the subdiagnostic of these conditions would determine a budget impact of at least 0.86%, only with pharmacological treatment.

PCV48

COST-EFFECTIVENESS ANALYSIS AND BUDGET IMPACT OF CONCOR® AM VERSUS BISOPROLOL PLUS AMLODIPINE IN SYSTEMIC ARTERIAL HYPERTENSION TREATMENT, FROM THE PERSPECTIVE OF THE BRAZILIAN PUBLIC HEALTH SYSTEM

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OBJECTIVES: Systemic arterial hypertension (SAH) is a chronic condition, and despite the large number of available antihypertensive drugs, patients with SAH who are drug-treated frequently do not obtain goal Blood Pressure (BP) levels. A combination of drugs is recommended for those cases, however, compliance is improved when agents are prescribed as fixed dose combinations rather than separate pills. A combination of bisoprolol and amlodipine once a day showed a rapid reduction of BP after 4 weeks. The aim of this paper is to perform cost-effectiveness (CE) and budget impact (BI) analyses of Concor® AM compared to amlodipine + bisoprolol as separate tablets. **METHODS:** A daily-cycle markov model was built considering the outcomes: days on treatment; number of events (stroke, myocardial infarction, heart failure and angina); number of full-lifetime-patients with transitory drug interruption (non-compliance); number of full-lifetime-patients with normal blood pressure and days of life. Efficacy data were obtained from literature review and unit costs were obtained from official price lists. The time horizon of the CE and BI model was 30 and 10 years, respectively. A 5% annual discount rate was applied in costs and benefits in the CE model. **RESULTS:** Concor® AM increased overall survival in 43 days and assured more 2,090 days on treatment, per patient, during lifetime period. Also, reduced 183 events, and allowed more 187 patients with controlled blog pressure, per 1,000 patients. Concor® AM was dominant vs. Concor + Amlodipine, resulting in financial resource saving of approximately 8.1% (BRL 5,720.72 per patient). Additionally, the use of Concor® AM in patients with SAH resulted in financial resource saving of approximately BRL 300,321,412.45, in the period from 2014 to 2025. **CONCLUSIONS:** Fixed-dose combinations such as Concor-AM do represent an opportunity to increase compliance and consequently health outcomes and its costs.

PCV49

ESTIMATED SAVINGS IN MEDICAL COSTS WHEN NEW ORAL ANTICOAGULANTS ARE USED FOR THE TREATMENT OF PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION AND VENOUS THROMBOEMBOLISM VS. WARFARIN IN THE U.S

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OBJECTIVES: The objective of this study was to estimate the overall differences in medical costs when nonvalvular atrial fibrillation and venous thromboembolism (VTE) patients are treated with each of the new oral anticoagulants (NOACs), dabigatran, rivaroxaban, apixaban, and edoxaban vs. warfarin. **METHODS:** Medical cost differences associated with NOAC use for patients treated for NVAF and acute VTE were obtained from previous publications and were based on clinical event rates from clinical trials. The medical cost differences associated with edoxaban vs. warfarin among NVAF patients were estimated as done previously for other NOACs. A hypothetical health plan population with 1 million members was used to estimate and compare the medical cost differences associated with use of each of the NOACs vs. warfarin among the combined NVAF and VTE populations. Prevalence rates of NVAF and VTE were derived from published literature. The same hypothetical usage rate (i.e. 10%) for each NOAC was assumed to facilitate the comparison of the medical cost differences. The medical cost differences of NOACs vs. warfarin were projected in the years 2015-2018. **RESULTS:** In 2014, in a hypothetical population of 1 million health plan members, medical costs were estimated to be reduced by the greatest amount for NVAF and VTE patients treated with apixaban ($11.5 million), followed by those treated with edoxaban ($6.6 million), rivaroxaban ($4.2 million), and dabigatran ($3.7 million). Medical cost savings associated with use of any of the NOACs were projected to increase from 2014 to 2018. **CONCLUSIONS:** Based on our economic analysis using clinical trial data, treatment of patients with NVAF and VTE with any of the NOACs instead of warfarin is associated with savings in medical costs, with apixaban being associated with the greatest savings in medical costs. The direct application of the results to the real-world setting will require further assessment.

PCV50

A RETROSPECTIVE ANALYSIS OF HEALTH CARE RESOURCE UTILIZATION AND THE ECONOMIC BURDEN AMONG U.S. LONG-TERM CARE FACILITY PATIENTS DIAGNOSED WITH STROKE

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OBJECTIVES: To assess the economic burden and health care resource utilization among patients in long-term care facilities who were diagnosed with stroke. **METHODS:** Patients diagnosed with stroke (International Classification of Diseases, 9th Revision, Clinical Modification diagnosis codes 433, 434 and 436) were identified using the Long Term Care Minimum Data Set (MDS) linked to 5% Medicare data from 01JAN2009 through 31DEC2010. The initial diagnosis date was designated as the index date. Patients without a stroke diagnosis (control cohort) were matched to stroke patients, and 1:1 propensity score matching (PSM) was used to control for age, region, gender and baseline Charlson Comorbidity Index score. The index date for the control cohort was randomly chosen to reduce selection bias. Patients in both cohorts were required to be age ≥65 years, have at least two consecutive quarterly assessments documented in MDS data 6 months prior to the index date and have continuous medical and pharmacy benefits 1 year before and after the index date. **RESULTS:** Once PSM was applied, 1,014 patients were included in each cohort, and baseline characteristics were balanced. A higher percentage of stroke patients had inpatient admissions (40.34% vs. 23.37%, p<0.0001), outpatient visits (92.31% vs. 89.45%, p=0.0253), skilled nursing facility (SNF; 37.67% vs. 28.21%, p<0.0001) and durable medical equipment (DME) claims (30.47% vs. 22.09%, p<0.0001) than those in the control cohort. Stroke patients also incurred considerably higher inpatient ($7,068 vs. $3,418, p<0.0001), outpatient ($3,545 vs. $2,539, p<0.0001), SNF ($8,036 vs. $3,695, p<0.0001), DME ($394 vs. $235, p=0.0023) and carrier claim costs ($3,606 vs. $2,489, p<0.0001) than those without a stroke diagnosis. **CONCLUSIONS:** Patients diagnosed with stroke had considerably higher health care resource utilization and costs than those in the control cohort.

PCV51

MEDICATION COST IMPLICATION FOR THE MANAGEMENT OF HYPERTENSION AND DIABETES IN NIGER DELTA: TERTIARY HOSPITAL BASED STUDY IN BAYELSA STATE, NIGERIA

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OBJECTIVES: To assess the economic burden of the management of hypertension and diabetes in two tertiary health facilities in Bayelsa State, Niger Delta, South-south Nigeria. **METHODS:** It is a retrospective review of randomly selected case notes of 531 hypertensive and diabetic patients. The demographics and cost of medicines prescribed were reviewed based on the hospital prices. These patients were randomly selected from those who attended the endocrinology and cardiology clinics of the health facilities in 2011 and 2012. **RESULTS:** Mean patients' age was 55.70±12.23 years. Most (42.2%) of them were civil servants while the rest were petty business owners (26.6%), retired workers (14.9%), farmers (10.3%), or unemployed (6%). The monthly average costs of all prescribed medications per patient for initiation and maintenance of therapy were ₦3333.43±2317.40 (US$18.17±12.60) and ₦4458.09±3064.8 (US$24.30±16.70) respectively (p < 0.05). Diuretics and sulphonylureas were the most economical of all the drugs prescribed monthly per patient accounting for ₦531.70 [US$2.90] and ₦559.10 [US$3.10] respectively for initiation of therapy, and ₦768.1 [US$4.20] and ₦631.1 [US$3.40] for maintenance of therapy. However, the most expensive of all the medicines were angiotensin receptor blockers which accounted for ₦4,368.8 [US$23.8] for initiation and ₦4,810.50 [US$26.20] for maintenance of therapy as well as insulins (at ₦2,448.20 [US$13.30] for initiation and ₦2,457.10 [US$13.40] for maintenance of therapy). **CONCLUSIONS:** Considering the poverty level in the Niger Delta region of Nigeria, the medication cost burden of managing hypertension and diabetes is high and unaffordable by most of the patients.

PCV52

ESTIMATING THE COST OF ILLNESS OF GIANT CELL ARTERITIS

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OBJECTIVES: Giant cell arteritis (GCA), a chronic vasculitis commonly presenting with headache, affects approximately 230,000 individuals in the US. However, limited data exist on the health care resource utilization and costs that are attributable to GCA. The objective of this study was to estimate the cost of illness in patients with GCA in the US. **METHODS:** A retrospective cohort of patients with a new diagnosis of GCA and five matched controls was identified from a large US claims database between January 1st 2008 and December 31st2011. Newly diagnosed GCA patients were defined by a diagnosis of GCA (ICD-9 446.5) during the study period and no GCA diagnosis in the 12 months prior. Controls were defined by absence of a GCA diagnosis. GCA patients and controls were matched on age, gender, region, index year of diagnosis, and index month of diagnosis. One-year healthcare costs were compared among cases and controls, adjusting for age, gender, Charlson Comorbidity Index (CCI), chronic disease count, U.S. region, health plan type (HMO vs. other), and year using generalized linear models. **RESULTS:** A cohort of 11,245 GCA patients and 56,230 controls was identified. The mean age of the cohort was 70 years and 71% were females. Mean CCI was 1.6 for GCA patients and 0.8 for controls. Mean one-year cost for GCA patients was $26,400 (SD: $48,500) and mean one-year cost for controls was $11,500 (SD: $29,200). After multivariate adjustment, the difference in one-year cost between GCA patients and controls was $4,800 (95% CI: $4,080—$5,520). **CONCLUSIONS:** Patients with GCA experience increased healthcare costs compared to patients without GCA after adjusting for covariates related to health care resource utilization and costs. Our results are the first to inform researchers, clinicians, and policymakers on the cost burden of GCA, estimated to be approximately $1 billion annually in the US.

PCV53

ACUTE, SHORT-TERM AND LONG-TERM COSTS OF CARDIOVASCULAR EVENTS AMONG HYPERLIPIDEMIA PATIENTS

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